

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004683	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility #: 004683</p> <p>Type of survey: State Licensure Off Site JSAHO Accreditation Survey</p> <p>Date of On Site JCAHO Full Hospital Survey October 16-17, 2012</p> <p>Date of ISDH Off Site Review- Sept. 5, 2013</p> <p>Reviewer: Nancy Otten, RN, PHNS</p> <p>Based on review of the 10/16-17/2012 JCAHO Accreditation Survey report, it has been determined that IU Health; Bedford, meets the requirements for Hospital Licensure in Indiana for 2012.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE